EDMUND G. BROWN JR.
Attorney General of California
ALFREDO TERRAZAS
Senior Assistant Attorney General
ARTHUR D. TAGGART
Supervising Deputy Attorney General
State Bar No. 083047
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 324-5339
Facsimile: (916) 327-8643

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **SHARON GAIL JONES SOUDERS, aka SHARON GAIL SOUDERS** 6291 Bilyeu Way Bend, OR 97701 Registered Nurse License No. 493858 Respondent.	Case No. 2010-184 **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

License History

2. On or about August 31, 1993, the Board of Registered Nursing issued Registered Nurse License Number 493858 ("license") to Sharon Gail Jones Souders, also known as Sharon Gail Souders ("Respondent"). The license was in full force and effect at all times relevant to the charges brought herein and expired on August 31, 2009.

///

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing ("Board"), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code ("Code"), unless otherwise indicated.

4. Code section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with Code section 2750) of the Nursing Practice Act.

5. Code section 2764, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

6. Code section 118, subdivision (b), provides that the suspension, expiration, surrender, or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

STATUTORY PROVISIONS

7. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.
>
> (f) Conviction of a felony or of any offense substantially related to the qualifications, functions, and duties of a registered nurse, in which event the record of the conviction shall be conclusive evidence thereof.

///

///

///

COST RECOVERY

8. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FIRST CAUSE FOR DISCIPLINE

(Out-of-State Discipline)

9. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(4), on the grounds of unprofessional conduct, in that Respondent's Registered Nurse License was disciplined by the Oregon State Board of Nursing ("Oregon Board"). In the action entitled, *In the Matter of the License to Practice as a Registered Nurse of: Sharon Gail Souders, RN,* pursuant to the Final Order in Case No. 08-289, effective February 11, 2009, Respondent's Registered Nurse License No. 200742756RN was revoked. The circumstances of the revocation are that on or about February 6, 2008, Respondent abused and/or neglected a patient by the use of excessive force and/or inappropriate conduct.

A copy of the Oregon Board's Final Order, Findings of Fact and Conclusions of Law is attached as Exhibit A, and is incorporated herein.

SECOND CAUSE FOR DISCIPLINE

(Criminal Conviction)

10. Respondent is subject to disciplinary action under Code section 2761, subdivision (f), in that on or about February 19, 2009, in the Circuit Court of the State of Oregon for the County of Deshutes, in the case entitled, *State of Oregon v. Sharon Gail Souders* (Circuit Ct. Deshutes County, 2008, Case No. 08FE0410MA), Respondent was convicted on her plea of guilty of violating ORS 163.160 (Assault in the 4th Degree), a misdemeanor, as a result of her actions on February 6, 2008, as referenced above in paragraph 9. Such crime is substantially related to the qualifications, functions, and duties of a registered nurse.

///

///

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 493858 issued to Sharon Gail Jones Souders, also known as Sharon Gail Souders;

2. Ordering Sharon Gail Jones Souders, also known as Sharon Gail Souders to pay the Board the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: 10/5/09

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SA2009310936
10495777.doc

OREGON STATE BOARD OF NURSING
STATE OF OREGON

In the Matter of the License to Practice as a Registered Nurse of:	)	**FINAL ORDER**
SHARON SOUDERS, RN	)	OAH Case No. 800513
	)	Agency Case No. 08-289

HISTORY OF THE CASE

On April 14, 2008, the Oregon State Board of Nursing (Board) issued a Notice of Proposed Revocation of Registered Nurse License, proposing to revoke Ms. Souders' license pursuant to ORS 678.111(1)(b), (f) and OAR 851-045-0015(1), (2), (3), (4), and (7). On April 24, 2008, Ms. Souders requested an administrative hearing. On April 25, 2008, the Board referred the hearing request to the Office of Administrative Hearings (OAH). The OAH assigned Senior Administrative Law Judge (ALJ) Jennifer H. Rackstraw to preside over the matter.

A telephone prehearing conference was held on July 15, 2008, with ALJ Rackstraw presiding. Attorney Thomas Doyle appeared on behalf of Ms. Souders. Assistant Attorney General (AAG) Joanna Tucker Davis appeared on behalf of the Board.

A hearing was held on November 19 and 20, 2008, in Portland, Oregon, with ALJ Rackstraw presiding. Attorney Doyle represented Ms. Souders. Ms. Souders testified on her own behalf. AAG Tucker Davis represented the Board. The following persons testified for the Board: Detective Devin Lewis, Bend Police Department; Ashley Evans, certified nursing assistant (CNA) at St. Charles Medical Center (SCMC); Mark Highland, RN at SCMC; Valerie Murray, former CNA at SCMC; Nancy Simonson, RN, manager at SCMC; Kari Eileen Coe, RN, nursing supervisor at SCMC; Susan Spehar, daughter of J.B.; Molly Casad, RN at SCMC; Kimberly Wood, RN, Board investigator; and Ms. Souders. The record closed at the conclusion of the hearing on November 20, 2008.

On January 21, 2008, ALJ Rackstraw issued a Proposed Order in this matter. The proposed order notified Respondent of her right to file exceptions within 10 days of service. Respondent did not file any exceptions.

In accordance with ORS 183.650(2) and -(3), and OAR 137-003-0665(3) and -(4), the Board must identify and explains those modifications to proposed findings of historical fact that change the outcome or basis for this Final Order from those in the proposed order. The Board has not made any changes that substantially modify the ALJ's proposed findings of historical fact. The Board has made other changes to fully, adequately or correctly set forth the material evidence in the record, to clarify, correct or amend the findings of the ALJ, and to explain the Board's

findings, conclusions, and opinion herein. The Board has also made changes to correct spelling, grammar, textual placement, and other similar errors.

ISSUES

1. Whether Ms. Souders demonstrated gross incompetence or gross negligence as a registered nurse. ORS 678.111(1)(b).

2. Whether Ms. Souders engaged in conduct derogatory to the standards of nursing under ORS 678.111(1)(f) and OAR 851-045-0070(1), (2), (3), (4), or (7).

3. If so, whether revocation of Ms. Souders' nursing license is the appropriate penalty.

EVIDENTIARY RULINGS

The Board offered Exhibits A1 through A18. Exhibits A1, A2, A4 through A11, and A13 through A18 were admitted into the record without objection. Exhibit A3 was admitted over Ms. Souders' relevancy objection and Exhibit A12 was admitted over Ms. Souders' hearsay objection.

CREDIBILITY DETERMINATION

The Board adopts the credibility determinations made by ALJ Rackstraw, which follow.

ORS 44.370 provides, in part:

> A witness is presumed to speak the truth. This presumption, however, may be overcome by the manner in which the witness testifies, by the character of the testimony of the witness, or by evidence affecting the character or motives of the witness, or by contradictory evidence.

Moreover, a determination of a witness' credibility can be based on a number of factors, other than the manner of testifying. These factors include the inherent probability of the evidence, whether or not the evidence is corroborated, whether the evidence is contradicted by other testimony or evidence, whether there are internal inconsistencies, and "whether human experience demonstrates that the evidence is logically incredible." *Tew v. DMV*, 179 Or App 443, 449 (2002), *citing Lewis and Clark College v. Bureau of Labor*, 43 Or App 245, 256 (1979) *rev den* 288 Or 667 (1980) (Richardson, J., concurring in part, dissenting in part).

Here, ALJ Rackstraw was concerned about the reliability of Ms. Souders' testimony. There are significant differences between Ms. Souders' account of the events of February 6, 2008 and the accounts of Ashley Evans, Valerie Murray, and Mark Highland. On both direct and cross-examination, Ms. Evans, Ms. Murray, and Mr. Highland were forthright regarding their recollection of the events of February 6, and they admitted when they either did not know the answer to a question or could not remember a particular detail. Although their testimony

differed regarding certain aspects of what they personally observed on February 6, in general, their testimony was consistent.

The testimony of Ms. Evans, Ms. Murray, Mr. Highland, and Susan Spehar regarding what occurred *after* Ms. Souders' alleged conduct towards J.B. on February 6 is also consistent with the conduct having occurred. Ms. Evans testified that she was upset after having witnessed some of the alleged conduct, and that it led her to question whether she wanted to continue working as a CNA. Ms. Murray testified that she was upset and angry after having witnessed some of the alleged conduct, and her written statement prepared on February 6 indicates that she required time alone to calm herself after the incident. Mr. Highland testified that he ordered Ms. Souders to leave J.B.'s room, he called a supervisor, and he subsequently sent Ms. Souders home after witnessing some of the alleged conduct. Ms. Spehar testified that J.B. was agitated and fearful on the morning of February 7, and that J.B. seemed fearful and did not want to be left alone for several days afterwards. This all points to the likelihood that the alleged conduct occurred.

Ms. Souders has provided several inconsistent statements regarding details of her interactions with J.B. on February 6. During a meeting with nursing manager Nancy Simonson and several other individuals on February 7, 2008, Ms. Souders denied putting her hand directly on J.B.'s face. However, during a February 27, 2008 interview with Detective Lewis, Ms. Souders admitted that she tried to force J.B.'s mouth open by pinching on the area between J.B.'s upper lip and nose, that she tried rubbing J.B.'s throat to get her to open her mouth and to swallow custard, and that she put pressure on J.B.'s forehead to get her to tilt her head back. At hearing, she also admitted to pinching the area between J.B.'s upper lip and nose and pushing down on J.B.'s chin.

Moreover, during the February 27 interview, Ms. Souders told Detective Lewis that she noticed blood coming from J.B.'s nose. However, at hearing she testified that she did not observe any blood on J.B. In addition, when recounting the events of February 6 at hearing, Ms. Souders made no mention of rubbing J.B.'s throat to get her to open her mouth or to get her to swallow custard.

Ms. Souders testified that when she met with Ms. Simonson on February 7, she informed her that J.B. had bitten down on the medicine cup the previous day and that she had been trying to remove the cup to prevent J.B. from harming herself. However, Ms. Simonson testified that Ms. Souders did not mention the medicine cup during the February 7 meeting. Ms. Simonson's written notes regarding the meeting support her testimony. ALJ Rackstraw found, and the Board concurs, that, more likely than not, Ms. Souders did not mention a medicine cup to Ms. Simonson on February 7. In turn, ALJ Rackstraw found, and the Board concurs, that it was improbable that Ms. Souders would have failed to mention the medicine cup to Ms. Simonson on February 7 if J.B. had, in fact, bitten down on the cup as Ms. Souders subsequently claimed.

In addition, Ms. Souders' testimony regarding her failure to document that J.B. had refused medication in the February 6 nursing progress note was not logically credible. She testified that she thought she had completed her progress note on J.B. and she thought she had charted that J.B. had gotten confused about taking her medications. However, the progress note

contains no mention of J.B. refusing medication, or of any other details regarding J.B.'s behavior with regard to medication administration that evening. Even if Ms. Souders' version of her interactions with J.B. are to be believed, it is not probable that Ms. Souders would have neglected to document such significant occurrences (*i.e.* J.B.'s refusal to take the medication, J.B.'s crushing of and spitting out of some of the pills, J.B.'s grasping of the medicine cup between her teeth, J.B.'s bloody nose) in the note unless she was planning to minimize or cover up her actions.

It is not probable that Ms. Evans, Ms. Murray, and Mr. Highland have been untruthful regarding what they observed on February 6. There is no evidence that they had a specific interest in falsifying a complaint about Ms. Souders, or that they had a motive to have such an interest, when they first reported their observations regarding the interactions between Ms. Souders and J.B. Further, their statements regarding what they observed on February 6 have not changed significantly since that time.

Ms. Souders has motive to be untruthful in this matter because she is facing revocation of her RN license. Moreover, her testimony illustrates that she tends to blame other individuals for her decisions and not take responsibility for her actions. For example, in apparent attempts to deny or justify alleged behavior, she testified that SCMC had too many preceptors, that patients and staff lied about her, that she changed a patient's medication because other RNs changed medications, that J.B. was "feisty," and that SCMC management was confusing in its directives. Ms. Souders' propensity to blame others, justify unfavorable conduct, and deny personal responsibility for her actions weighs against her when assessing her credibility.

Finally, Ms. Souders had motive to commit the alleged conduct on February 6. At the time of her interaction with J.B., she was one hour late dispensing medications. In addition, she had ongoing difficulty with SCMC's pain management philosophy, and she had previously been counseled for failing to proactively manage patients' pain. She has admitted that she was experiencing stress due to the pain management issue and her feeling that SCMC managers were watching her "like a hawk."

In sum, and for the reasons set forth above, ALJ Rackstraw found, and the Board concurs, that Ms. Souders' testimony was not credible. Where her testimony conflicts with other evidence, ALJ Rasckstraw accorded, as does the Board, greater weight to the other evidence.

FINDINGS OF FACT

ALJ Rackstraw found, and the Board concurs with, the following findings of fact:

1. In 1993, Ms. Souders became a licensed registered nurse (RN) in California. In August 2007, she became a licensed RN with the Oregon State Board of Nursing (Board). (Test. of Souders.)

2. In August 2007, Ms. Souders began working as an RN in the Ortho-Neuro unit at St. Charles Medical Center (SCMC). (Test. of Souders.) The unit houses post-operative patients,

orthopedic patients, neurosurgical patients, stroke patients, and trauma/ICU patients. (Test. of Coe, Evans.)

3. When an experienced RN begins work in the Ortho-Neuro unit at SCMC, he or she receives three to four weeks of floor orientation. As an experienced RN, this was the amount of orientation Ms. Souders received. (Test. of Coe.) During her first month of employment, she was assigned to work with various preceptors.[1] (Test. of Souders.)

4. Ms. Souders noticed some differences between her work at SCMC and her work as an RN in California. One difference was that at SCMC she had many different preceptors and they provided her with conflicting information. Another difference was that SCMC was more proactive in managing patients' pain and dispensing pain medications. A third difference was that the RNs at SCMC relied on CNAs to check the pain levels of patients, even though SCMC management told Ms. Souders that she needed to check patients' pain levels. (Test. of Souders.)

5. SCMC's policy is that a patient should not be subjected to any procedure without his or her voluntary consent, or that of a legally authorized representative. Also, a patient may refuse treatment, to the extent permitted by law. (Ex. A4 at 4-5; test. of Simonson.) If a patient expresses that he or she does not want to take medication when offered, an RN can try to educate the patient about the benefits of taking the medication, allow another nurse to try and administer the medication, or delay administration of the medication until the patient has time to calm down. If the patient refuses to take the medication, the RN should note that fact in the patient's record. It is not acceptable nursing practice to force a patient to take medication against her will, with the exception of a patient on a psychiatric hold who attempts to injure herself or others. (Test. of Highland, Wood, Coe.)

6. On September 24, 2007, in response to a complaint from a CNA that Ms. Souders' patients were not promptly receiving pain medication, nursing supervisor Kari Coe spoke with Ms. Souders, in part, regarding pain management at SCMC. They discussed ways that Ms. Souders could minimize disruptions to sleeping patients while still checking the patients' pain levels. Ms. Coe told Ms. Souders that she should not let patients sleep all night long without checking their pain levels. Ms. Coe also told Ms. Souders that patients have the right to refuse medications, and that an RN's job is to educate patients about the value of pain management. (Test. of Coe; Ex. A15.)

7. In October 2007, a day shift RN complained that Ms. Souders was not adequately medicating patients for pain during the night shift. On or about October 17, 2007, Ms. Coe met with Ms. Souders. Ms. Coe told Ms. Souders that Ms. Souders was required to offer pain medications to post-operative patients during the night, and that she was required to document any medication refusals. They discussed an RN's role in educating patients about pain management. Ms. Coe told Ms. Souders that she should offer patients pain medications at the appropriate times, encourage them to take the medications, explain to reluctant patients that they want to maintain a pain level of no more than three on a scale of ten, and try to alleviate any concerns patients might have about narcotic addiction. (Test. of Coe, Souders; Ex. A15.)

---

[1] Preceptors are nurses who have received specialized training regarding the training of other nurses. (Test. of Casad.)

8. On November 7, 2007, Ms. Coe and nursing manager Nancy Simonson met with Ms. Souders regarding pain management. Ms. Souders received a written corrective action. Ms. Coe and Ms. Simonson informed Ms. Souders that she would be paired with preceptor Molly Casad for a few nights as additional training. Ms. Souders subsequently worked with Ms. Casad for three 12-hour shifts in December 2007. (Test. of Coe.) Ms. Souders told Ms. Casad that Ms. Souders was being told by management to force medication on patients. Ms. Casad told Ms. Souders that such a directive sounded odd and that it was not the practice of SCMC to forcibly medicate. Ms. Casad provided positive feedback to management regarding Ms. Souders' work performance during the three shifts in December 2007. (Test. of Coe, Casad.)

9. Even after Ms. Coe instructed Ms. Souders to wake patients during the night to check their pain levels, Ms. Souders gave patients the option of being awakened every four hours or sleeping through the night. (Test. of Souders.)

10. In approximately October 2007, Ms. Souders changed a medication order for a patient. Instead of an order for two tablets of Vicodin, which each contain 325 milligrams (mg) of Tylenol, she changed the order to Norco 10, which contains the same amount of Vicodin but half the amount of Tylenol. (Test. of Souders, Coe.) Ms. Souders received a final written action for her conduct in changing the medication order. (Test. of Coe.)

11. On or about February 6, 2008, J.B., a 76-year-old female, was admitted to SCMC because of multiple bouts of infection and fever, and a sudden decrease in her mental status. J.B. had the following diagnoses: osteoarthritis, peripheral neuropathy, hypertension, osteoporosis, GERD, COPD, depression, hypothyroidism, gout, sacral pressure ulcer, diabetes mellitus, recurrent pneumonia, and recurrent UTIs. She had previously lost her left leg to cancer, one of her shoulders had a persistent dislocation, she could not raise her arms above chin level, she experienced chronic back pain, and arthritis in her hands interfered with her ability to hold objects. (Ex. A1 at 1; test. of Wood, Spehar.) She also experienced confusion and memory loss, similar to the early stages of Alzheimer's. (Ex. A12 at 3.)

12. J.B. received oxygen therapy through a nasal cannula—tubing from a wall adapter that delivers oxygen through the nostrils. A nasal cannula may cause a person's nasal passages to become dry, possibly resulting in a nosebleed. (Test. of Highland.)

13. On February 6, 2008, CNA Ashley Evans worked the evening shift at SCMC and was assigned to assist Ms. Souders with a group of patients that included J.B. At approximately 10:00 p.m., Ms. Evans was at the nurse's station, located outside of J.B.'s room. Ms. Souders looked out of J.B.'s door and asked for Ms. Evans to come inside of J.B.'s room and assist her. Ms. Evans went into J.B.'s room and, at Ms. Souders' request, held onto J.B's left hand. Ms. Evans assumed that Ms. Souders wanted her to hold J.B.'s hand in an attempt to calm J.B. In a raised, angry voice, Ms. Souders told J.B. that if J.B. did not take her medication, Ms. Souders would call J.B.'s daughter and her daughter would make her take the medication. J.B. told Ms. Souders that she did not want to take the medication. J.B. was grinding her teeth and crying. Ms. Souders reached over J.B., pinched J.B.'s nose with one hand, put some pills into J.B.'s mouth with her other hand, and then held J.B.'s mouth shut with her hand. In response, J.B. shook her

head and tried to spit out the pills. J.B.'s nose began bleeding from the nostrils. Ms. Evans was uncomfortable by what she witnessed, and started to leave J.B.'s room. Ms. Souders told Ms. Evans to bring Ms. Souders some custard. Ms. Evans knew that nurses sometimes used custard to try and get patients to take pills. Ms. Evans left J.B.'s room. (Test. of Evans; Ex. A8 at 2.)

14. While Ms. Evans was in J.B.'s room with J.B. and Ms. Souders, CNA Valerie Murray was outside of the room, stocking a nearby server cupboard. Ms. Murray heard aggressive yelling from Ms. Souders, as Ms. Souders told J.B. to take the medications and threatened to call her daughter if she did not take them. Ms. Murray could see Ms. Souders leaning towards J.B. and yelling at her to take her pills. Ms. Murray believed that Ms. Souders was behaving more aggressively than was appropriate. Ms. Murray was angry and upset by what she witnessed. (Test. of Murray; Ex. A8 at 3.)

15. Once outside of J.B.'s room, Ms. Evans saw Ms. Murray. Ms. Murray noticed that Ms. Evans seemed upset. Ms. Murray asked Ms. Evans if what Ms. Murray thought was going on inside of J.B.'s room was really happening. Ms. Evans told Ms. Murray that it was true and that she was uncomfortable about it. Ms. Evans then walked towards the supply room to get the custard. (Test. of Evans, Murray; Ex. A8 at 3.)

16. At approximately 10:15 p.m., Ms. Murray contacted the charge nurse, Mark Highland, and told him that she believed something was "going on" in J.B.'s room, that Ms. Souders was yelling at J.B., and that he needed to come to J.B.'s room immediately. (Test. of Highland, Murray; Ex. A8 at 3.)

17. Ms. Evans got a cup of custard from the supply room, dropped the custard on a chair in J.B.'s room, and left the room. When she dropped the custard on the chair, she overheard Ms. Souders telling J.B. that she was going to take the pills, and J.B. saying that she did not want to take the pills. Ms. Evans then went to find Mr. Highland to report what she had observed. Another nurse informed Ms. Evans that Ms. Murray had already reported the incident to Mr. Highland, and that Mr. Highland had already gone to J.B.'s room. (Test. of Evans; Ex. A8 at 2.)

18. Immediately after receiving the call from Ms. Murray, Mr. Highland went to J.B.'s room, where he stood in the doorway and observed what was occurring. Ms. Souders had some custard and a spoon and was trying to give J.B. pills with the custard. Ms. Souders told J.B. not to spit the pills out at her or she would call J.B.'s daughter. J.B. spit the pills out, and Ms. Souders collected the pills with the spoon and put them back into J.B.'s mouth with the spoon. Ms. Souders then placed a hand over J.B.'s mouth, pushed J.B.'s head back onto her pillow, leaned in towards J.B.'s face, and yelled loudly at J.B., "You take your pills!" Mr. Highland intervened and ordered Ms. Souders to leave J.B.'s room. J.B. appeared visibly scared. J.B. had oxygen tubing in her nose and blood coming from both nostrils. Ms. Highland asked J.B. if she knew where she was, to which J.B. responded, "I just don't understand why." He informed J.B. that she would be safe, and he had a CNA comfort J.B. and clean the blood off her face. (Test. of Highland; Ex. A8 at 1.)

19. Mr. Highland spoke to Ms. Souders shortly after ordering her to leave J.B.'s room. He informed her that she could no longer take care of J.B. He then contacted Ms. Coe to report

the incident. Ms. Coe instructed him to contact Ms. Simonson. Ms. Simonson instructed Mr. Highland to send Ms. Souders home for the night. Mr. Highland subsequently told Ms. Souders to leave for the night. (Test. of Highland; Ex. A8 at 1.)

20. Ms. Evans was upset by what she had witnessed between Ms. Souders and J.B., and she questioned whether she wanted to continue working as a CNA if the behavior she witnessed from Ms. Souders was a regular occurrence in her line of work. (Test. of Evans.) Ms. Murray was emotional and tearful about what she had observed between Ms. Souders and J.B., and she required some time alone to calm herself. (Test. of Murray; Ex. A8 at 3.) At approximately 10:30 p.m. on February 6, Ms. Evans and Ms. Murray prepared incident reports, in which they described in detail what they witnessed occurring between Ms. Souders and J.B. (Test. of Evans, Murray; Ex. A8 at 2-3.) Mr. Highland also prepared an incident report. (Ex. A8 at 1.)

21. At SCMC, an RN must chart all medications administered to a patient on the electronic medication administration record (eMAR) at the time the medications are administered. The chart note must include the site, route, and dosage of the medications. If a scheduled medication is not given, the RN must chart "not done" and document the reason in the Nursing Progress notes. If a medication is charted in error, the RN must right-click on the dose and "un-chart" the dose. (Ex. A16 at 9.) Without exception, an RN must document an occurrence with a patient in the patient's Nursing Progress note. (Test. of Coe.)

22. On February 6, 2008, J.B. was scheduled to take the medication warfarin at 9:00 p.m. At 10:12 p.m., Ms. Souders charted on the eMAR that J.B. had taken the warfarin. Also at 10:12 p.m., Ms. Souders "un-charted" that the warfarin had been administered. At 10:46 p.m., Ms. Souders charted that the warfarin was "not given" to J.B., because "patient refused." (Ex. A7 at 6; test. of Coe.)

23. At 10:57 p.m. on February 6, 2008, Ms. Souders documented a Nursing Progress note regarding J.B. The note contained the following information:

> *Nursing Data:* assumed care of patient at 1900. sound asleep. lungs course with rhonchi. o2 2liter nc on hob 40. resp. unlabored. iv fluids infusing. pat stirs a little when touched. other wise sleepy. sp. cath. draining urine.
>
> *Nursing Action:* monitor alertness as needed. assist with adl's and continue with current plan of care.
>
> *Nursing Response*: sleeping.

(Ex. A7 at 1; emphasis in original.) The note did not document that J.B. had refused medication that night. (Ex. A7 at 1; test. of Coe.)

24. On the morning of February 7, 2008, J.B.'s daughter, Susan Spehar, visited J.B. at SCMC. Ms. Spehar noticed that J.B. was very agitated, and she seemed fearful. Ms. Spehar was unaware of the events of February 6 when she made these observations. Ms. Spehar also noticed

that J.B. had some abrasions, bruises, and dried blood in her nostrils. For several days following February 6, J.B. acted frightened and did not want Ms. Spehar to leave her alone. (Test. of Spehar.)

25. On February 7, 2008, Ms. Coe and Ms. Simonson met with Ms. Souders. During the meeting, Ms. Souders told them that she had encouraged J.B. to take her medications on February 6, and that she had put her hand in front of J.B.'s mouth so that if J.B. spit the pills out, they would not hit Ms. Souders. She did not make any mention of a medicine cup. She denied speaking aggressively to or shouting at J.B. (Test. of Simonson; Ex. A10.)

26. Once J.B. indicated that she did not wish to take the medications offered to her by Ms. Souders on February 6, and J.B. began exhibiting anxiety or agitation over the administration of the medications, Ms. Souders should have stopped trying to administer the medications. Ms. Souders could have contacted the charge nurse on the unit for assistance, asked a CNA to sit with J.B. to calm her down, or called J.B.'s daughter to request her assistance in encouraging J.B. to take the medication. (Test. of Wood.)

27. On February 13, 2008, SCMC reported the February 6 incident to the Board. (Ex. A11.) On February 14, 2008, the Board assigned investigator Kimberly Wood to the case. On February 15, 2008, Ms. Wood sent Ms. Souders a letter, requesting, among other things, that Ms. Souders contact the Board by February 22, 2008 to set up a time to meet with Ms. Wood at the Board's office in Portland. (Test. of Wood; Ex. A17 at 1, 8.) The letter also contained the following information:

> Failure to cooperate with the Board during the course of an investigation is viewed as non-compliance with a Board request and as such you may be subject to disciplinary action per OAR 861-045-0015(7)(a) and (c). Failure to attend your appointment, as well as canceling and rescheduling more than one time will be considered non-cooperation with the Board.

(Ex. A17 at 8.)

28. On February 15, 2008, Ms. Wood left Ms. Souders a voicemail message. At approximately 4:00 p.m. that day, Ms. Souders returned Ms. Wood's call. During their phone conversation, Ms. Wood informed Ms. Souders that a complaint had been filed with the Board regarding the incident with J.B. Ms. Wood explained the allegations to Ms. Souders. Ms. Souders became emotional and stated that the allegations against her were incorrect and that the witnesses were lying. Ms. Wood informed Ms. Souders that she needed to participate in an interview at the Board's Portland office. Ms. Souders indicated that getting to Portland would be financially difficult for her. Ms. Wood told Ms. Souders that the interview could not be conducted by phone. Ms. Souders told Ms. Wood that she had retained attorney Tom Doyle. Ms. Wood asked Ms. Souders to provide the Board with a Letter of Intent to Represent from Mr. Doyle. Ms. Souders agreed to do so, and indicated that she would be forwarding all documents to Mr. Doyle before discussing or signing anything. (Test. of Wood; Ex. A17 at 2.)

29. On February 15, 2008, Ms. Wood reported the incident between Ms. Souders and J.B. to the Bend Police Department. Officer David Poole conducted an initial investigation into the matter, which included interviews with Ashley Evans and Mark Highland. (Ex. A12.) Detective Devin Lewis subsequently took charge of the investigation. He interviewed Ms. Spehar, Ms. Murray, and Ms. Souders. (Test. of Lewis.)

30. On February 19, 2008, Ms. Wood called Ms. Souders and informed her that the Board had not received the Letter of Intent to Represent from Mr. Doyle. Ms. Souders told Ms. Wood that she had been in contact with Mr. Doyle's office that day, but that Mr. Doyle had been unavailable the past two days due to court and a holiday. Ms. Wood reminded Ms. Souders that the letter regarding the interview with Board staff was in the mail, and she told Ms. Souders to share the letter with Mr. Doyle as soon as possible so they could schedule an interview. Ms. Wood told Ms. Souders that it was imperative that she have the interview with Board staff as soon as possible. (Ex. A17 at 2.)

31. During a typical investigative interview with a licensee, Ms. Wood explains the investigation process, reviews the licensee's work practice and educational background, discusses the allegations against the licensee, discusses the Nurse Practices Act, and asks the licensee if there is anyone with whom the investigator should speak who might have information about the case. (Test. of Wood.)

32. On or about February 21, 2008, a Board staff person scheduled a Board interview with Ms. Souders for March 12, 2008. (Test. of Wood; Ex. A7 at 3.)

33. On February 27, 2008, Detective Lewis interviewed Ms. Souders. Ms. Souders informed Detective Lewis that J.B. initially consented to taking the medication on February 6. Ms. Souders stated that when she tried to put the cup of pills into J.B.'s mouth, J.B. bit onto the cup and would not let go. Ms. Souders stated that she tried to force J.B.'s mouth open by pinching on the area between J.B.'s upper lip and nose, and that she also tried rubbing J.B.'s throat to get her to open her mouth. Ms. Souders stated that when she pulled on the area between J.B.'s upper lip and nose, it appeared to cause J.B.'s nose to bleed. Ms. Souders stated that she asked Ms. Evans to help by holding J.B.'s hand down so that Ms. Souders could get the cup out of her mouth. Ms. Souders stated that after getting the cup out of J.B.'s mouth, she raised her voice to tell J.B. that she needed to take the pills because she thought that J.B. might have some hearing problems. Ms. Souders stated that even though J.B. continued to refuse the pills, Ms. Souders put a pill in some custard and put it in J.B.'s mouth. Ms. Souders stated that J.B. started to chew the pill and spit some of the custard out. Ms. Souders stated that she put her hand over J.B.'s mouth so J.B. could not spit the custard out all over the place. Ms. Souders stated that she rubbed J.B.'s throat to try and get her to swallow the pill and custard. Ms. Souders stated that she touched J.B.'s forehead and used gentle pressure to get her to tilt her head back so she could swallow the pills. Ms. Souders admitted to Detective Lewis that she felt some adrenaline at the time and that she had been upset. Ms. Souders admitted that she was stressed during that period of time because she was on probation at SCMC due to her different views regarding pain control and she felt like she was being closely watched. At the conclusion of the interview, Detective Lewis placed Ms. Souders under arrest for Criminal Mistreatment I, Coercion, and Assault IV. (Exs. A13, A14; test. of Lewis.)

34. On March 10, 2008, Mr. Doyle called Ms. Wood and cancelled the appointment scheduled for March 12, stating that there was a criminal case pending against Ms. Souders and Ms. Souders would not be able to answer any questions regarding the matter. (Ex. A17 at 3; test. of Wood.)

35. On March 11, 2008, Ms. Wood mailed a letter to Ms. Souders, c/o Mr. Doyle. In the letter, she provided three potential dates for a Board interview with Ms. Souders. She also indicated that she would consider other dates, if the three dates she suggested did not work for Ms. Souders. The letter contained no deadline for a response from Ms. Souders. (Ex. A7 at 3, 6; test. of Wood.)

36. When Ms. Wood did not receive a response from Ms. Souders by March 19, 2008, she sent Ms. Souders' case to the Board for a review and determination. (Ex. A17 at 3; test. of Wood.) If Ms. Souders had contacted Ms. Wood to schedule an interview prior to the Board's review, Ms. Wood would have pulled the case from the Board's consideration and proceeded with an interview. (Test. of Wood.)

37. On April 9, 2008, the Board voted for revocation of Ms. Souders' license based on the February 6, 2008 incident and Ms. Souders' failure to cooperate with the Board's investigation. (Test. of Wood; Ex. A17 at 4.)

38. On April 25, 2008, Ms. Wood received a letter from Mr. Doyle, dated April 24, 2008. (Ex. A17 at 9-10; test. of Wood.) The letter provided, in part:

> We are available to meet at the Board of Nursing on any date, at any time, and for as long as you choose. There should be no question that we are willing to cooperate with you in regard to this investigation.

(Ex. A17 at 10.)

CONCLUSIONS OF LAW

1. Ms. Souders demonstrated gross incompetence as a registered nurse. ORS 678.111(1)(b).

2. Ms. Souders engaged in conduct derogatory to the standards of nursing under ORS 678.111(1)(f) and OAR 851-045-0070(1), (2), (3), (4), and (7).

3. Revocation of Ms. Souders' nursing license is the appropriate penalty.

OPINION

Jurisdiction over this matter lies with the Board. ORS 678.111. The Board bears the burden of establishing by a preponderance of the evidence that revocation of Ms. Souders' nursing license is warranted. ORS 183.450(2) ("The burden of presenting evidence to support a

fact or position in a contested case rests on the proponent of the fact or position"); *Harris v. SAIF*, 292 Or 683, 690 (1982) (general rule regarding allocation of burden of proof is that the burden is on the proponent of the fact or position); *Metcalf v. AFSD*, 65 Or App 761, 765 (1983) (in the absence of legislation specifying a different standard, the standard of proof in an administrative hearing is preponderance of the evidence). Proof by a preponderance of the evidence means that the fact finder is persuaded that the facts asserted are more likely than not true. *Riley Hill General Contractors v. Tandy Corp.*, 303 Or 390, 402 (1987).

1. Gross incompetence or gross negligence under ORS 678.111(1)(b)

The Board has proposed to revoke Ms. Souders' nursing license under ORS 678.111(1)(b), which provides in relevant part:

> (1) Issuance of the license to practice nursing, whether by examination or by indorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the board may impose or may be issued a limited license or may be reprimanded or censured by the board, for any of the following causes:
>
> * * * * *
>
> (b) Gross incompetence or gross negligence of the licensee in the practice of nursing at the level for which the licensee is licensed.

It is clear that SCMC places a high priority on proactively managing patients' pain. Managers at SCMC expect RNs to wake patients at set intervals throughout the night, check pain levels, offer pain medications, and attempt to educate and encourage patients who are reluctant to take such medications. Even so, SCMC prohibits a nurse from forcibly medicating patients, except where a patient is on a psychiatric hold and is attempting harm to herself or others.

Nurse supervisor Coe counseled Ms. Souders on three occasions in late 2007 regarding SCMC's medication administration policies. On those occasions, Ms. Souders and Ms. Coe discussed a patient's right to refuse medication, as well as strategies for educating and encouraging patients to take pain medications when appropriate. In addition, SCMC provided Ms. Souders with additional training regarding medication administration by having her shadow a nurse preceptor in December 2007.

The preponderance of the evidence establishes that on February 6, 2008, Ms. Souders used aggressive and threatening language and physical force while attempting to administer medications to J.B. against her will. In so acting, Ms. Souders failed to follow acceptable nursing protocol. Even if J.B. had initially consented to take the medications, as Ms. Souders claims, once J.B. demonstrated an unwillingness to take the medications (by crying, gritting her teeth, spitting pills out, and explicitly saying that she did not want to take the medications), Ms. Souders should have stopped trying to administer them. Consistent with SCMC's policy of

encouraging patients to take pain medications, Ms. Souders could have employed alternative strategies such as seeking assistance from the charge nurse, asking a CNA to assist in calming J.B., and calling J.B.'s daughter to request her assistance. By failing to employ any of those strategies, and instead attempting to medicate J.B. with physical force and other aggressive and threatening behavior, Ms. Souders has demonstrated gross incompetence in the performance of her duties as an RN. Thus, she violated ORS 678.111(1)(b).

2. Conduct Derogatory to the Standards of Nursing

The Board has also proposed to revoke Ms. Souders' nursing license under ORS 678.111(1)(f). The statute allows the Board to revoke or suspend a nursing license for "conduct derogatory to the standards of nursing." The Board has defined "conduct derogatory to the standards of nursing" in OAR 851-045-0070, and relevant portions of the rule are set forth as follows:

> Nurses, regardless of role, whose behavior fails to conform to the legal standard and accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to, the following:
>
> (1) Conduct related to the client's safety and integrity:
>
> (a) Developing, modifying, or implementing standards of nursing practice/care which jeopardize patient safety.
>
> (b) Failing to take action to preserve or promote the client's safety based on nursing assessment and judgment.
>
> (c) Failing to develop, implement and/or follow through with the plan of care.
>
> (d) Failing to modify, or failing to attempt to modify the plan of care as needed based on nursing assessment and judgment, either directly or through proper channels.
>
> * * * * *
>
> (l) Failing to respect the dignity and rights of clients, regardless of social or economic status, age, race, religion, sex, sexual orientation, national origin, nature of health needs, or disability.
>
> * * * * *
>
> (2) Conduct related to other federal or state statute/rule violations:

(a) Abusing a client. The definition of abuse includes, but is not limited to, intentionally causing physical or emotional harm or discomfort, striking a client, intimidating, threatening or harassing a client, wrongfully taking or appropriating money or property, or knowingly subjecting a client to distress by conveying a threat to wrongfully take or appropriate money or property in a manner that causes the client to believe the threat will be carried out.

(b) Neglecting a client. The definition of neglect includes but is not limited to carelessly allowing a client to be in physical discomfort or be injured.

(c) Engaging in other unacceptable behavior towards or in the presence of a client such as using derogatory names or gestures or profane language.

* * * * *

(3) Conduct related to communication:

* * * * *

(i) Failing to communicate information regarding the client's status to other individuals who need to know; for example, family, facility administrator.

(4) Conduct related to achieving and maintaining clinical competency:

* * * * *

(b) Failing to conform to the essential standards of acceptable and prevailing nursing practice. Actual injury need not be established.

* * * * *

(7) Conduct related to the licensee's relationship with the Board:

* * * * *

(c) Failing to fully cooperate with the Board during the course of an investigation, including, but not limited to, waiver of confidentiality privileges, except client attorney privilege.

Ms. Souders has violated all of the above provisions. The conduct relevant to those provisions is examined below below.

A. Conduct towards J.B.

As previously set forth, on February 6, 2008, Ms. Souders used aggressive and threatening language and physical force while attempting to administer medications to J.B. against her will. Her conduct violates OAR 851-045-0070(1)(a)-(d), (l), (2)(a)-(c), and (4)(b).

J.B. was a frail woman with numerous medical conditions. Ms. Souders' conduct in pinching J.B.'s nose in an apparent attempt to get J.B. to open her mouth and her conduct in placing pills and custard in J.B.'s mouth and then holding her hand over J.B.'s mouth and pushing J.B.'s head back onto a pillow in an apparent attempt to get J.B. to swallow medication against her will jeopardized J.B.'s safety. This conduct violates OAR 851-045-0070(1)(a) and (b).

Ms. Souders argues that J.B. initially agreed to take her medications when Ms. Souders offered them to her. Even assuming that is true, at some point during their interaction, J.B. told Ms. Souders that she did not want to take the medication, she spit the medication out of her mouth, she gritted her teeth, and she cried. At a certain point, J.B. clearly evidenced her desire not to take the medication. Ms. Souders should have, at that point, ceased trying to administer the medication and availed herself of one of the many alternatives at her disposal—including seeking assistance from the charge nurse, asking a CNA to assist in calming J.B., calling J.B.'s daughter to request her assistance, and/or simply waiting for a later time to attempt to educate and encourage J.B. to take the medication. Ms. Souders failed to exercise sound judgment in utilizing one of those alternatives, in violation of OAR 851-045-0070(1)(c) and (d), and instead attempted to forcibly medicate J.B. In so doing, Ms. Souders failed to respect J.B.'s dignity and her right to refuse medication, in violation of OAR 851-045-0070(1)(l).

OAR 851-045-0070(2)(a) defines "abuse" to include intentionally intimidating, threatening, or harassing a client. Ms. Souders' threats to call J.B.'s daughter on February 6 if J.B. did not take her medications meet that definition of "abuse." Moreover, I find that Ms. Souders' use of loud, aggressive, and threatening language towards J.B. constitutes unacceptable behavior under OAR 851-045-0070(2)(c).

In addition, the preponderance of the evidence supports the fact that J.B.'s nose began bleeding *after* Ms. Souders pinched it. Although the cannula may have contributed to some extent to the nosebleed, I find it more likely than not that the pinching of the nose *caused* J.B.'s nose to bleed. Under OAR 851-045-0070(2)(b), Ms. Souders neglected J.B. because in trying to forcibly medicate her, Ms. Souders carelessly allowed J.B. to experience physical discomfort or injury.

Finally, the evidence produced at hearing establishes that it is not acceptable nursing practice to forcibly medicate a patient, unless the patient is on a psychiatric hold and is attempting to harm herself or others. Because there is no evidence that J.B. was on a psychiatric hold, or that she was attempting to hurt herself or others, Ms. Souders' attempt to forcibly medicate J.B. failed to conform to acceptable nursing practice, in violation of OAR 851-045-0070(4)(b).

B. Nursing Progress Note for J.B.

By failing to honestly and accurately fill out the progress note for J.B., Ms. Souders violated OAR 851-045-0070(3)(i) and (4)(b).

An RN at SCMC is required, without exception, to document an occurrence with a patient in the patient's Nursing Progress note. At 10:57 p.m. on February 6, 2008, Ms. Souders documented a Nursing Progress note regarding J.B. While the note contained certain medical and other information about J.B., it did not note that J.B. had refused to take medication at approximately 10:15 p.m. that evening, nor did it include any other significant information regarding Ms. Souders' interactions with J.B. that evening. In failing to document J.B.'s medication refusal and the significant circumstances surrounding that refusal, Ms. Souders failed to conform to the essential standards of acceptable nursing practice, in violation of OAR 851-045-0070(4)(b). In addition, her conduct violates OAR 851-045-0070(3)(i) because she failed to communicate information regarding J.B.'s status to other individuals.

C. Cooperation with the Board

Ms. Souders failed to fully cooperate with the Board during the investigation, in violation of OAR 851-045-0070(7)(c). Specifically, Ms. Souders failed to promptly respond to a request for a Board interview.

Board investigator Wood emphasized to Ms. Souders during a phone call on February 19, 2008, that she wished to have a personal interview with Ms. Souders in Portland, and that she wished to do so as soon as possible. The Board scheduled such an interview for March 12, 2008. On March 10, 2008, Ms. Souders, through her attorney, cancelled the interview, claiming that because of her pending criminal case she would be unable to answer questions pertaining to the Board's investigation. On March 11, 2008, Ms. Wood mailed a letter to Ms. Souders, through her attorney, indicating that Ms. Souders needed to reschedule her Board interview and offering three potential interview dates.

Ms. Souders, through her attorney, was aware within a few days of March 11, 2008, that the Board still wished to schedule an interview with her. However, it was not until April 25, 2008 that the Board received a response from Ms. Souders, through her attorney, dated April 24, 2008, indicating that she was willing to participate in an interview and fully cooperate with the Board. By that time, the Board had already voted for revocation of Ms. Souders' RN license and notified her of that fact.

There is no intent or *mens rea* requirement when a licensee is charged with failing to cooperate with the Board during the course of an investigation. The violation arises out of a failure to act when there is an obligation to do so. Therefore, whether Ms. Souders acted willfully in failing to promptly contact the Board to schedule an interview is immaterial to whether a violation occurred. Ms. Souders' failure to contact the Board at any time between mid-March 2008 and April 24, 2008 to reschedule an interview constitutes a failure to fully

cooperate with the Board during its investigation. Thus, Respondent violated ORS 678.111(1)(f) and OAR 851-045-0070(7).

3. Penalty

The Board proposed revocation of Ms. Souders' license for the violations set forth above. Ms. Souders contended that a lesser penalty is appropriate. Not only is revocation warranted under ORS 678.111(1), but that lesser penalties, such as probation or additional training, will be ineffective because Ms. Souders has already demonstrated that those approaches were ineffective for her at SCMC. Ms. Souders maintained, however, that she has responded well to training in the past because shadowing Ms. Casad was beneficial for her. While Ms. Souders may have received some professional benefit from shadowing Ms. Casad, it is significant that even after receiving repeated counseling from Ms. Coe regarding medication administration, Ms. Souders still chose not to follow SCMC policy and allowed some patients to sleep through the night without checking their pain levels. This intentional disregard for policy weighs against Ms. Souders when determining whether lesser penalties are appropriate for the violations she has committed.

Given the aggressive nature of Ms. Souders' actions towards J.B., her failure to honestly and accurately fill out J.B.'s progress note, her unwillingness to admit to any wrongdoing with respect to the matters asserted and proven herein, her propensity for blaming others for her actions, and the fact that the February 6 incident was not an isolated instance of poor nursing practice, revocation is consistent with the Board's interest in protecting the health, safety, and welfare of patients. Revocation of Ms. Souders' registered nurse license is the appropriate penalty in this case.

ORDER

Sharon Souders' registered nurse license is revoked.

Dated this 11th day of FEBRUARY 2009.

FOR THE OREGON STATE BOARD OF NURSING

James E. McDonald, RN, Board President

APPEAL RIGHTS

You may file a petition for reconsideration or rehearing of this Order. Reconsideration or rehearing may be obtained by filing a petition with the Board within 60 days from the service of this Order. Your petition shall set forth the specific grounds for reconsideration. Reconsideration or rehearing is pursuant to the provisions in ORS 183.482.

As an alternative to filing a Petition for Reconsideration of this Order, you are entitled to judicial review of this Order. Judicial review may be obtained by filing a petition with the Oregon Court of Appeals for review within 60 days from the date of service of this Order. Judicial review is pursuant to the provisions of ORS 183.482 to the Oregon Court of Appeals.

APPENDIX A
LIST OF EXHIBITS CITED

Ex. A1: Admission history for J.B., St. Charles Medical Center.

Ex. A4: Patients' Rights & Responsibilities.

Ex. A7: Progress Notes, Orders, and Adult Ongoing Assessment of J.B.

Ex. A8: Event Detail History with All Tasks.

Ex. A10: Typewritten notes by Nancy Simonson, RN.

Ex. A11: Letter to Board of Nursing from Jane Hanson, dated February 13, 2008.

Ex. A12: Report of Offense by Officer David Poole, Bend Police Department.

Ex. A13: Supplemental Report by Detective Devin Lewis, Bend Police Department.

Ex. A14: Interview of Sharon Souders by Detective Lewis.

Ex. A15: Notes regarding discussions with Sharon Souders by Kari Coe, RN.

Ex. A16: Work instructions regarding medication, administration, and documentation.

Ex. A17: Notes of Board Investigator Wood; various correspondences.

BEFORE THE BOARD OF NURSING
OF THE STATE OF OREGON

In the Matter of	)	AMENDED
	)	NOTICE OF PROPOSED
	)	REVOCATION OF
	)	REGISTERED NURSE LICENSE
	)	
Sharon Gail Souders, RN	)	
License No.200742756RN	)	Case No. 08-289
	)	

To: Sharon Gail Souders, RN

The Oregon State Board of Nursing (Board) proposes to revoke your Registered Nurse license on the following grounds:

I

On or about February 6, 2008 Licensee abused and/or neglected a patient by the use of excessive force and/or inappropriate conduct.

Licensee scheduled an interview with Board staff on March 12, 2008. On March 12, 2008, Licensee cancelled the interview via her attorney. Board staff sent a letter to Licensee, through her attorney, requesting that she re-schedule the interview. Despite attempts by Board staff, no response has been forthcoming.

II

The above conduct constitutes a grave danger to public health and safety, and by the above actions Licensee is subject to discipline pursuant to violations of ORS 678.111(1) (b) and (f) and OAR 851-045-0015 (1) (a) and (b) and (c) and (d) and (l); (2) (a) and (b) and (c) and (j); (3) (i); (4) (b) and (7) (c) which reads as follows:

678.111 Causes of denial, revocation or suspension of license or probation, reprimand or censure of licensee. In the matter prescribed in ORS chapter 183 for a contested case:

(1) Issuance of the license to practice nursing, whether by examination or by endorsement, of any person may be refused or the license may be revoked or suspended or the licensee may be placed on probation for a period specified by the Oregon State Board of Nursing and subject to such condition as the Board may impose or may be issued a limited license or may be reprimanded or censured by the Board for any of the following causes:

(b) Gross incompetence or gross negligence of the licensee in the practice of nursing at the level for which the licensee is licensed.

(f) Conduct derogatory to the standards of nursing.

Conduct Derogatory to the Standards of Nursing Defined
OAR 851-045-0015

Nurses, regardless of role, whose behavior fails to conform to the legal standard and accepted standards of the nursing profession, or who may adversely affect the health, safety, and welfare of the public, may be found guilty of conduct derogatory to the standards of nursing. Such conduct shall include, but is not limited to, the following:

(1) Conduct related to the client's safety and integrity:

(a) Developing, modifying, or implementing standards of nursing practice/care which jeopardize patient safety.

(b) Failing to take action to preserve or promote the client's safety based on nursing assessment and judgment.

(c) Failing to implement and/or follow through with the plan of care.

(d) Failing to modify, or failing to attempt to modify the plan of care as needed based on nursing assessment and judgment, either directly or through proper channels.

(l) Failing to respect the dignity and rights of clients, regardless of social or economic status, age, race, religion, sex, sexual preference, national origin, nature of health problems or disability.

(2) Conduct related to other federal or state statute/rule violations:

(a) Abusing a client. The definition of abuse includes but is not limited to intentionally causing physical harm or discomfort, striking a client, intimidating, threatening or harassing a client.

(b) Neglecting a client. The definition of neglect includes but is not limited to carelessly allowing a client to be in physical discomfort or be injured.

(c) Engaging in other unacceptable behavior towards or in the presence of a client such as using derogatory names or gestures or profane language.

(j) Failing to conduct practice without discrimination on the basis of age, race, religion, sex, sexual preference, national origin, nature of health problems or disability.

(3) Conduct related to communication:

(i) Failing to communicate information regarding the client's status to other individuals who need to know; for example, family, facility administrator.

(4) Conduct related to achieving and maintaining clinical competency:

(b) Failing to conform to the essential standards of acceptable and prevailing nursing practice. Actual injury need not be established.

(7) Conduct related to the licensee's relationship with the Board:

(c) Failing to fully cooperate with the Board during the course of an investigation, including, but not limited to, waiver of confidentiality privileges, except client-attorney privilege.

The foregoing is grounds to revoke your Registered Nurse license in the State of Oregon.

Dated this 5th day of June 2008

FOR THE BOARD OF NURSING OF THE STATE OF OREGON

Linda Fisher-Lewis
Program Manager
Investigations, Compliance and Practice

Notice of Hearing Rights and Exhibit A attached.